

**Indiana Family and Social Services Administration**

**Notice of Public Hearing and Public Comment Period**

Pursuant to 42 CFR Part 431.408, notice is hereby given that: (1) on May 28, 2014, at 9:00 a.m., at the Indiana Government Center South, Conference Center Room B, 402 West Washington Street, Indianapolis, Indiana 46204-2744; and (2) on May 29, 2014, at 1:00 p.m., at the Indiana State House, Room 156-B, 200 West Washington Street, Indianapolis, Indiana 46204-2786, the Indiana Family and Social Services Administration (“FSSA”) will hold public hearings on the Healthy Indiana Plan 2.0 1115 demonstration waiver (“HIP 2.0 Waiver”) application that will be submitted to the Centers for Medicare and Medicaid Services (“CMS”) to extend and expand the current Healthy Indiana Plan (“HIP”) for calendar years 2015 through 2019. Both public hearings will be accessible via web conference at <http://www.webinar.in.gov/hip/>. In addition, FSSA will present the HIP 2.0 Waiver to the Medicaid Advisory Committee on Wednesday, June 4, 2014 at 10:00 a.m. at the Indiana War Memorial, Shoup Hall, 431 North Meridian Street, Indianapolis, IN 46204.

This notice also serves to open the **30-day public comment period, which closes June 21, 2014 at 4:30 pm.**

The Healthy Indiana Plan (“HIP”), which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the state’s long and successful history with consumer-driven health plans. The HIP 2.0 Waiver proposes a series of modifications to the current HIP program (“HIP 2.0”) and seeks to expand the program to all non-disabled adults between the ages of 19 and 64 with household income below 138% of the federal poverty limit (“FPL”). HIP 2.0 will continue to offer its members, via private health insurance carriers, a High Deductible Health Plan (“HDHP”) paired with a Personal Wellness and Responsibility (“POWER”) account, which operates similarly to a Health Savings Account (“HSA”). This private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to have “skin in the game,” which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for their health. HIP, in its current form, is scheduled to expire on December 31, 2014.

FSSA is submitting the HIP 2.0 Waiver concurrently with a separate Healthy Indiana Plan 1115 waiver extension request (“HIP Extension Waiver”), which seeks to extend the current HIP program in its existing form through 2017. FSSA is submitting the HIP Extension Waiver as an alternative to the HIP 2.0 Waiver in order to preserve the current HIP program in the event CMS does not approve the HIP 2.0 Waiver.

**OBJECTIVES**

HIP 2.0 furthers HIP’s core objectives: 1) reduce the number of uninsured, low income Hoosiers and increase access to healthcare services; 2) promote value-based decision-making and personal health responsibility; 3) promote disease prevention and health promotion to achieve better health outcomes; 4) promote private market coverage and family coverage options to reduce network and provider fragmentation within families; 5) facilitate HIP member access to job training and stable employment to reduce dependence on public assistance; and 6) assure State fiscal responsibility.

**BENEFICIARIES, ELIGIBILITY, & FINANCING**

HIP 2.0 offers health care coverage to non-disabled individuals between the ages of 19 and 64, who have household incomes below 138% of the FPL and who are not otherwise eligible for Medicaid or Medicare. Income eligibility for HIP is determined using the modified adjusted gross income (“MAGI”) methodology with a 5% disregard. HIP 2.0 augments the existing program by offering HIP to individuals previously excluded from the program due to the program’s eligibility restrictions and the enrollment caps. First, Section 1931 parents and caretaker relatives, who are currently covered under the Hoosier Healthwise (“HHW”) program, will be transferred to HIP. In addition, HIP 2.0 will remove the existing 36,500 enrollment cap on non-caretaker adults allowed to participate in the program.

Recognizing the strong tie between work and health, HIP 2.0 promotes employment by introducing the HIP’s Gateway to Work program. This program requires all HIP members who are unemployed or working less than 20 hours a week to be referred, as a condition of eligibility, to the State’s workforce training programs and work search

resources. Full-time and part-time students will be exempted from the referral for each year they are enrolled in a postsecondary education institution or technical school.

HIP 2.0 enrollment, including the addition of Section 1931 parents and caretaker relatives, is projected to expand HIP coverage to approximately 600,000 by demonstration year five. Over the five-year demonstration period (2015-2019), HIP 2.0 is expected to cost approximately \$2.4 billion in state funds, and \$20.9 billion in total combined state and federal funds. The table below provides the estimated state and federal costs divided by year.

**Estimated State and Federal Program Costs 2015-2019 (in millions)**

Calendar Year	Demonstration Year	Expenditures without Waiver	Total HIP 2.0 Expenditures	State Share of HIP 2.0 Expenditures	Waiver Margin
2015	1	\$ 2,779.7	\$ 3,145.2	\$ 358.2	(\$365.4)
2016	2	\$ 4,064.6	\$ 4,077.3	\$ 329.8	(\$12.7)
2017	3	\$ 4,481.1	\$ 4,349.2	\$ 511.2	\$ 131.9
2018	4	\$ 4,775.6	\$ 4,554.6	\$ 570.7	\$ 221.0
2019	5	\$ 5,089.4	\$ 4,796.6	\$ 637.2	\$ 292.8

## **BENEFITS AND HEALTH CARE DELIVERY SYSTEM**

HIP offers its members a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account, which operates similarly to a Health Savings Account (HSA), used to fund the plan's \$2,500 deductible, as more fully described in the cost-sharing section below. Current HIP benefits are authorized as Secretary-approved coverage. HIP is not presently benchmark-equivalent coverage as it does not cover maternity services and includes a \$300,000 annual and \$1 million lifetime coverage limit. HIP 2.0 benefits will be updated to offer a comprehensive benefits plan that meets Alternative Benefit Plan ("ABP") requirements. Preventive services, such as annual examinations, smoking cessation programs, and mammograms are covered without charge to the member and are not included in the deductible amount. After the \$2,500 deductible is met through the utilization of POWER account funds, the HIP program includes a comprehensive benefit package, which includes physician services, inpatient/outpatient hospital services, maternity services, emergency transportation, prescription drugs, diagnostic services, durable medical equipment and medical supplies, rehabilitative services, home health services, and mental health and substance abuse services. HIP 2.0 will eliminate the lifetime and annual coverage limits, and maternity services will be added as an option in all HIP benefit plans. However, the State intends to maintain its waiver for non-emergency transportation.

Under HIP 2.0, members who consistently make required contributions to their POWER account will maintain access to a new "HIP Plus" plan that includes enhanced benefits, such as dental and vision coverage. Members under 100% FPL who do not make monthly POWER account contributions will be placed in the "HIP Basic" plan, a more limited benefit plan, which will also require co-payments for all services in lieu of the monthly POWER account contributions. Members under 100% FPL will have a choice of 1) the HIP Basic benefit package that applies co-payments to services or 2) the enhanced HIP Plus benefit package that requires members to make contributions to their POWER account; while members above 100% FPL will utilize the HIP Plus plan.

Enrollees who are pregnant, Section 1931 parents and caretaker relatives, or qualify as medically frail will be enrolled in HIP but will receive benefits equivalent to coverage on the State Plan. Consistent with 42 CFR §440.315(f), an individual will be considered "medically frail" if he or she has one or more of the following: 1) disabling mental disorder; 2) a chronic substance abuse disorder; 3) serious and complex medical condition; 4) physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activity of daily living; or 5) a disability determination, based on Social Security Administration criteria. The State will implement robust retrospective and prospective screening processes to identify medically frail individuals through the HIP application process as well as through claims data.

In addition, the HIP 2.0 Waiver also proposes the implementation of a new optional defined contribution premium assistance program, HIP Employer Benefit Link ("HIP Link"), designed to support individuals wishing to purchase their employer-sponsored insurance ("ESI"). Eligibility for HIP Link will be determined as follows: (i) individual

must be eligible for HIP but not considered medically frail, (ii) individual must be 21 years of age or older, (iii) individual must have access to and be eligible to participate in their ESI, and (iv) the employer must be contributing at least 50% of the premium cost. The State will not provide wrap-around benefits, as election to participate in the ESI plan through HIP Link is optional. To ensure the quality of ESI plans, all small group plans must provide essential benefits and all large group and self-insured plans are subject to the minimum value requirements and are recognized as minimum essential coverage.

All HIP medical benefits are currently provided through three managed care entities (“MCE”), Anthem, MDwise, and Managed Health Services. At the time of application, HIP members have access to enrollment brokers, who provide counseling on the full spectrum of available MCE choices, to assist with their MCE selection, and, if applicable, counseling regarding the HIP Link option, including assistance evaluating their ESI plan. For HIP members, once an MCE has been selected, the member must remain in the MCO for 12 months, with limited exceptions. Members who do not select an MCE will be auto-assigned to an MCE but will have the opportunity to change the assigned MCE before the first POWER account contribution is made.

### **COST SHARING REQUIREMENTS**

HIP utilizes two forms of cost-sharing: POWER account contributions and co-payments to promote consumerism and personal responsibility. The State ensures these costs do not exceed 5% of family income. HIP provides each member with an HSA-like account - the POWER account - to cover the plan’s deductible. Instead of traditional cost-sharing of premiums and co-payments, most HIP members make upfront monthly contributions to the POWER account. The State pre-funds the difference between the member’s required annual POWER account contribution and the plan’s deductible to ensure adequate funding for deductible expenses early in the benefit period. Once the POWER account contribution is made, the individual has no additional cost-sharing except for a co-payment for inappropriate emergency department usage. HIP 2.0 will maintain the existing cost-sharing structure with the following modifications:

1. *Adjusting the required contributions and calculation methodology.* Currently, as a condition of eligibility, all members are required to make monthly POWER account contributions based on a sliding fee scale, reflecting approximately 2% of the member’s household income. HIP 2.0 proposes to replace the current member contributions with a new flat rate contribution level based on FPL as set forth in the table below. The set contribution levels are intended to simplify program administration, facilitate clear communication with members, and increase affordability. In addition, members choosing to enroll in their ESI plans through the HIP Link option will be required to pay the same monthly contributions consistent with the HIP Plus levels set forth below.

**POWER Account Flat Rate Monthly Contributions by FPL**

<b>FPL</b>	<b>Proposed Monthly Contribution</b>	<b>2012 Average Monthly Contribution</b>
<22%	\$3	\$7.94
23%-50%	\$8	\$10.32
51%-100%	\$15	\$17.77
101%-138%	\$25	\$39.69*

\* The amount shown represents the average 2012 monthly contribution for members 100-150% FPL.

2. *Modifying non-payment penalties.* Under the current HIP structure, members must make regular monthly contributions to their POWER account, or face disenrollment from the program and a 12 month lock-out period. Due to proposed changes in the program structure, the HIP 2.0 would modify the non-payment penalties. Specifically, for members at or above 100% FPL, the State plans to maintain the current lock-out structure for non-payment, but with a reduction in the lock-out period from 12 months to 6 months. By contrast, for individuals below 100% FPL, in lieu of disenrollment, the member would be transferred to the HIP Basic plan, which, as described above, would provide a reduced benefit package and require co-payments for all services, in accordance to the table below. Although HIP Basic plan members will not be required to make POWER account contributions, the members will continue to manage a POWER account in order to continue to promote HIP’s principles of consumerism.

**HIP Basic Plan Co-payment Schedule**

Service	HIP Basic Plan Co-Pay Amounts
Preventive Care Services	\$0
Outpatient Services	\$4
Inpatient Services	\$75
Preferred Drugs	\$4
Non-preferred drugs	\$8
Non-emergency ED visit	Up to \$25

3. *Increasing the POWER account maximum.* HIP 2.0 seeks to increase the amount of the POWER account to \$2,500 (rather than the current \$1,100) to better align with the current HSA standard and increase the amount of dollars members are managing. However, despite the increase in the deductible, the required member contribution will not increase, and, instead, the State would contribute more to the account, thereby providing more dollars for the member to directly manage.
4. *Modifying the POWER account rollover process.* The POWER account roll-over process will be modified under HIP 2.0 to reflect the overall increase in the POWER account value, alteration in member contributions, and increased State contributions to the account. HIP Plus members who have a remaining POWER account balance at the end of the year will be able to roll over their share to the next plan year. As an added bonus, if the HIP Plus member receives their recommended preventive care services during the year, the State will match their rollover amount, doubling the amount of the member's personal share of the POWER account. The total amount will then be used to reduce required contributions in future plan years. Members in the HIP Basic plan are only eligible to reduce their required HIP Plus annual contributions in the following year by up to half if they receive recommended preventive care services while on the HIP Basic plan.
5. *Introducing a graduated co-payment amount for inappropriate emergency department (ED) utilization.* HIP currently charges co-payments to discourage inappropriate use of emergency services. Non-caretakers must currently pay \$25 co-payments for inappropriate ED use, while parents and caretaker relatives must pay \$3. The HIP 2.0 Waiver seeks to test a graduated co-payment applicable to all HIP members (except pregnant women) regardless of HIP benefit package or FPL, whereby the first inappropriate emergency department visit would require an \$8 co-payment; and subsequent inappropriate visits would require a \$25 co-payment. ED copayments will be waived for any member who contacts their MCE's 24 hour nurses hotline prior to utilizing a hospital ED.
6. *Alternative cost-sharing structure for pregnant women.* In accordance with federal law, pregnant women will be exempt from all cost-sharing for the duration of their pregnancy and for 60 days following delivery.

**HYPOTHESES & EVALUATION**

The HIP 2.0 Waiver will investigate the following research hypotheses related to each program goal:

1. **Goal 1: Reduce the number of insured low income Hoosiers and increase access to health care services.**
  - a. Hypotheses:
    - i. HIP will reduce the number of insured Hoosiers with income under 138% FPL.
    - ii. HIP will increase access to quality health care services among the target population.
  - b. Evaluation:
    - i. Track rates of uninsured Hoosiers with income below 138% FPL.

- ii. Track the number of Hoosiers served by the HIP program.
- iii. Track member feedback for perceived access to different types of healthcare services before and after enrollment in the HIP program.
- iv. Measure geo-access standards for primary and specialty care for all health plans.
- v. Measure member health plan satisfaction indicators.

**2. Goal 2: Promote value-based decision making and personal health responsibility.**

a. Hypotheses:

- i. HIP policies will encourage member compliance with required contributions and provide incentives to actively manage POWER account funds.
- ii. HIP Plus members will exhibit more cost-conscious healthcare consumption behavior than HIP Basic members and traditional Hoosier Healthwise members.
- iii. HIP's emergency department ("ED") utilization policies (including the graduated copayments for non-emergent use of the ED) will deter inappropriate ED utilization.

b. Evaluation:

- i. Track initial HIP Plus vs. HIP Basic enrollment by FPL.
- ii. Track HIP members making initial and subsequent POWER account contributions.
- iii. Track and compare average remaining POWER account balances.
- iv. Track HIP Plus member POWER account rollover rates and the average amount by which contributions are reduced in the next benefit period for base rollovers and preventive care rollovers.
- v. Track the average amount by which required contributions are discounted for HIP Basic members transitioning to HIP Plus at redetermination.
- vi. Track the copayment collection rate for HIP Basic members.
- vii. Track health service utilization rates for the following groups (controlling for health status, age and other relevant variables)—HIP Plus members, HIP Basic members who enrolled in HIP Plus at the end of the period, and HIP Basic member who do not enroll in HIP Plus at the end of the period.
- viii. Compare annual rates of inappropriate ED utilization between HIP population for the years before and after the change in ED policy.
- ix. Compare annual rates of alternative urgent care setting utilization between HIP population for years before and after the change in ED policy.
- x. Survey HIP members on whether the copayment for non-emergency use of the ED caused them to seek services with their primary care physician or alternative urgent care setting.
- xi. Compare annual rates of members seeking prior authorization through the nurses' hotline prior to seeking ED services.
- xii. Compare annual rates of members paying increased copayments based on repeated inappropriate ED utilization.

**3. Goal 3: Promote disease prevention and health promotion to achieve better health outcomes.**

a. Hypothesis:

- i. HIP will effectively promote member use of preventive, primary and chronic disease management care to achieve improvements health outcomes.

b. Evaluation:

- i. Track and compare health service utilization rates between HIP and traditional Medicaid members.
- ii. Track and compare POWER account rollover and contribution discount rates for HIP Plus members and HIP Basic members who enroll in HIP Plus at the end of a benefit period.
- iii. Track preventive care utilization rates and trends among different age and gender groups.
- iv. Track participation in health plan's chronic disease management programs.

4. **Goal 4: Promote private market coverage and family coverage options to reduce provider and network fragmentation within families.**

a. Hypotheses:

- i. HIP Link will increase the proportion of Hoosiers under 138% FPL covered by employer-sponsored insurance (ESI).
- ii. HIP's ESI premium assistance option for family coverage will increase the number of low income families in which the parents and children have access to the same provider network.

b. Evaluation:

- i. Track Hoosiers with income under 138% FPL covered by ESI over the demonstration.
- ii. Track Hoosiers with income under 138% FPL receiving defined contribution premium assistance to purchase ESI each year of the demonstration.
- iii. Track the number of parents eligible for and utilizing premium assistance for their children to enroll in the family coverage ESI plan in lieu of CHIP.

5. **Goal 5: Facilitate HIP member access to job training and stable employment to reduce dependence on public assistance.**

a. Hypothesis:

- i. Referrals to the Department of Workforce Development employment resources at the time of application will increase member employment rates over demonstration.

b. Evaluation:

- i. Track the number of HIP applicants referred for work search and job training assistance.
- ii. Track the number of HIP members who participate in work search/job training programs.
- iii. Compare rates of full and part-time employment among the enrolled population at application and after six months, one year, and two years into the program.
- iv. Track the number of HIP individuals transitioning off the program due to increased income.

6. **Goal 6: Assure State fiscal responsibility and efficient management of the program.**

a. Hypothesis:

- i. HIP will remain budget-neutral for both the federal and state governments.

b. Evaluation:

- i. Conduct budget neutrality analysis and document adherence to waiver margin.

## **WAIVER & EXPENDITURE AUTHORITIES**

The following includes a list of waiver and expenditure authorities for the HIP 2.0 Waiver:

1. **Amount, Duration, Scope, and Comparability**

Section 1902(a)(10)(B)

To the extent necessary to enable Indiana to vary services offered to individuals within eligibility groups or within the categorical eligible population, based on differing managed care arrangements or in the absence of managed care arrangements. To the extent necessary to enable Indiana to offer an alternative limited benefits package to HIP members under 100% FPL who do not make their POWER account contributions.

2. **Freedom of Choice**

Section 1902(a)(23)

To the extent necessary to enable Indiana to restrict the freedom of choice of providers for demonstration eligibility groups.

**3. Reasonable Promptness**

Section 1902(a)(3)/Section 1902(a)(8)

To the extent necessary to enable Indiana to prohibit re-enrollment for 6 months for HIP members above 100% FPL who are disenrolled for failure to make POWER account contributions. To the extent necessary to enable Indiana to delay provision of medical coverage until the first day of the month following an individual's first contribution to the POWER account.

**4. Methods of Administration: Transportation**

Section 1902(a)(4) insofar as it incorporates 42 CFR

431.53

To the extent necessary to enable Indiana not to assure transportation to and from medical providers for HIP members, except for those who are exempt from Alternative Benefit Plans and receiving State Plan benefits, including pregnant, individuals determined to be medically frail, and Section 1931 parents and caretaker relatives.

**5. Eligibility Section**

Section 1902(a)(10)(A)

To the extent necessary to enable Indiana not to provide medical coverage for HIP members enrolled in the HIP Plus plan above 100% FPL until the first day of the month following an individual's first contribution to the POWER account, or for members under 100% FPL who fail to make an initial POWER account payment within 60 days following the date of eligibility.

**6. Amount, Duration, and Scope of Services**

Section 1902(a)(10)(B)

To the extent necessary to enable Indiana to offer to HIP members, known as "the adult group" in the proposed rule at 42 CFR 435.119, benefits that differ from the benefits offered to the categorically needy group.

**7. Retroactive Eligibility**

Section 1902(a)(34)

To the extent necessary to enable Indiana not to provide medical coverage to HIP members in the HIP Plus plan for any time prior to the first of the month following an individual's first contribution to the POWER account, and to allow Indiana not to provide medical coverage to HIP members initially enrolled in the HIP Basic plan until after the date of the eligibility determination.

**8. Prepayment Review**

Section 1902(a)(37)(B)

To the extent necessary to enable Indiana not to ensure that prepayment review be available for disbursements by members of HIP to their providers.

**9. Cost-Sharing**

Section 1916A

To the extent necessary to enable Indiana to require POWER account contributions for members in the HIP Plus plan, co-payments up to 5% of household income for HIP members in the HIP Basic plan, and graduated co-payments up to \$25 for all HIP members, except pregnant women, using a hospital emergency department for non-urgent care.

**10. Vision and Dental Coverage**

Section 1902(a)(34)

To the extent necessary to enable Indiana not to cover certain vision and dental services described in sections 1905(r)(2) and 1905(r)(3) of the Act to 19 and 20 year-old members of HIP who are enrolled in the HIP Basic plan for failure to make POWER account contributions.

**REVIEW OF DOCUMENTS AND SUBMISSION OF COMMENTS**

The proposed HIP 2.0 Waiver documents are available for public review at the FSSA, Office of General Counsel, 402 W. Washington Street, Room W451, Indianapolis, Indiana 46204. The documents may also be viewed online at [www.HIP.in.gov](http://www.HIP.in.gov).

Written comments regarding the HIP 2.0 Waiver may be sent to the FSSA via mail at 402 West Washington Street, Room W374, Indianapolis, Indiana 46204, Attention: Steve Holt or via electronic mail at [HIP2.0@fssa.in.gov](mailto:HIP2.0@fssa.in.gov) through June 21, 2014.

FSSA will publish a summary of the written comments, once compiled, for public review at [www.HIP.in.gov](http://www.HIP.in.gov).

